STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

In re: Stewart P. Manchester, M.D.	)	Docket Nos. MPC 24-0203
	)	MPC 75-0702
	)	
	)	
	)	

STIPULATION AND CONSENT ORDER

NOW COME Stewart P. Manchester, M.D. (Respondent), and the State of Vermont, by and through Attorney General William H. Sorrell and the undersigned Assistant Attorney General, James S. Arisman, and agree and stipulate as follows:

1. Stewart P. Manchester, M.D., Respondent, a St. Albans family practice physician, holds Vermont Medical License Number 042-0009040, issued by the Vermont Board of Medical Practice on December 23, 1994.

2. Jurisdiction vests with the Vermont Board of Medical Practice (Board) pursuant to 26 V.S.A. §§ 1353, 1354, 1361 & 1398.

I. Respondent's Care of Patient at Nursing Home.

3. The Board opened Docket No. MPC 75-0702, on July 30, 2002 following receipt of a complaint from the daughter of a male patient in his late-fifties (hereinafter referred to as Patient A), who had resided at a St. Albans area nursing home.

4. Beginning in 2001, Patient A had become effectively confined to nursing home residence and care.[1] Patient A suffered from a number of serious medical conditions and had become increasingly unable to care for himself. The daughter's complaint to the Board

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1. The nursing home had no full-time medical doctor on staff.

of Medical practice alleged her father had been Respondent Manchester's patient and that Dr. Manchester failed to respond to requests that he come to the nursing home to examine and care for the patient, after he had developed pressure sores due to his lack of mobility.[2] The Board's investigation of this matter included review of the complaint, examination of hospital and nursing home records, communication with the complainant and Respondent, interviews of individuals with pertinent information regarding this matter, receipt of a written response from Respondent, and a meeting between Dr. Manchester and the assigned Board investigative committee.

5. Respondent agreed in meeting with the investigative committee that he had not responded in a timely manner to requests that he provide care to the patient. Respondent observed, "This never should have happened." He indicated that there were mitigating circumstances in his view, i.e., an overly busy medical office and an apparent failure of office systems to reliably relay messages and ensure follow-up care. The committee concluded from its review of the facts that Respondent's care of the patient presented a unsatisfactory, mixed-picture as to Dr. Manchester's attention to the patient's medical needs.

6. Respondent's medical office is located six miles from the nursing home where Patient A was confined.

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2. It is well known that nursing home residents are at risk for pressure sores if confined to their beds for lengthy periods each day. Pressure sores also are known as decubitus ulcers or pressure ulcers. A decubitus ulcer can range from a mild pink discoloration of the skin, to a very deep wound extending through the skin and sometimes down to bone and internal organs. The usual source of a decubitus ulcer is pressure. Friction from a bed sheet or clothing is another source. Any area of tissue that lies just over a bone is a possible site for a decubitus ulcer. The individual's weight presses on the bone, the bone presses on the skin and tissue that cover it, and tissue is trapped between the bone and the bed or other underlying surface. The blood vessels in the skin and underlying tissue are compressed and tissue begins to decay from compromised circulation. A contributing factor is an altered nutritional state (i.e., poor appetite with weight loss). Additional factors include poor hygiene, incontinence, dehydration, and inactivity. Pressure ulcers can be expected to progress in seriousness without medical attention. The overriding concern is the development of infections that may become life threatening or lead to amputation.

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A. Information Taken from Patient's Medical Records.

7. Review of written medical records in this case indicated that nursing home staff clearly identified Patient A in November 6, 2001 as being at "high risk to develop pressure areas". Nursing notes for November 8, 2001 indicate that Patient A then had "raw" areas of skin on his buttocks and thighs. On November 16, 2001, the medical records indicate that Patient A had lost "a layer of skin" on his right ankle. On November 18, 2001, Patient A fell from his bed. During the next two days, Patient A experienced pain in his right ankle and was treated with a pain reliever. However, within a few days Patient A's right ankle had developed a one-centimeter open area of skin, with a "yellow green center". A protective dressing was applied. Respondent was notified by telephone of the medical problem. He came to the nursing home within four hours of being called on November 23, 2001, examined the wound, and wrote care orders.[3]

8. By December 13, 2001 Patient A's ankle sore appeared to have healed. The patient, however, continued to be treated for other pressure areas on his buttocks. On December 29, 2001, Respondent's practice partner came to the nursing home, examined the patient, and wrote a progress note that noted "no complaints" and "extremities—no edema".

B. Patient's Care in 2002.

9. On January 17, 2002, according to medical records, a telephone call was made to Respondent's office reporting that Patient A now had an "open area [right] talus". The medical records do not indicate that a return call was received from Respondent or that he visited the patient in response to this call. On January 21, 2002 a second telephone call was

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3. The investigative committee found Respondent's care note to be largely illegible and thus, it was not clear to the committee from the note precisely what care was rendered by Respondent on November 23, 2001. The patient's medical records appear to indicate that Respondent did not see his patient again for more than two months after the November 23, 2001 visit.

placed to Respondent reporting that the open area of the right talus (ankle) now had increased in size and depth. In this instance, the nursing home received a prompt return call from Respondent's office and a care order was entered by telephone. However, Respondent did not come to the nursing home to examine for himself Patient A's open pressure ulcer.

10. By January 28, 2002, Patient A was reported to be producing a "yellow brown drainage from the bottom of foot". His foot also was reported to be "spongy in texture." An entry in the patient's chart on January 29, 2002 states that a telephone call was placed to Respondent's office regarding the patient's condition, "[I] spoke [with] Jean [and] informed of visible tendon and requested that Dr. Manchester come in & see open area". The patient's medical records include no indication that Respondent returned this telephone call or responded to it by coming to the nursing home to examine the patient.

11. An entry in the patient's chart for January 30, 2002 states, "[Telephone call] to Dr. Manchester regarding open area on [right] foot. [He states] he will come tomorrow @ 2 pm—to see area." An entry in the chart for the next day, January 31, 2001 states, "dressing [changed] to Rt foot—tendon visible—scant yellow drainage noted on old dressing. Dr. Manchester not in to visit resident as expected." (Emphasis added.)

12. An entry in the patient's chart, for February 1, 2002, states, "I spoke [with] Dr. Manchester personally re exposed tendon on [right] foot—stressed repeatedly importance of him seeing resident. Dr. Manchester said 'I will try to come in at lunch time depending on how the day goes' [and he then] ordered a consult [with] Dr. Goering." Following the urging of this telephone call, both Dr. Goering, an area podiatrist, and Dr. Manchester came to the nursing home.[4] Dr. Manchester wrote a note, only partially legible, that appeared to refer to

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4. After the February 1, 2002 visit to Patient A, Respondent did not see his patient again.

obtaining a vascular consultation. On February 4, 2002, Patient A was transported to Burlington and was examined there by a vascular surgeon. Dr. Manchester's office called the nursing home the next day and prescribed painkillers for Patient A. Respondent

13. An entry in the patient's records for February 6, 2002 states, "[Dressing changed] to [right] foot red/edematous, warm to touch, green drainage from wound. very painfull [sic] holding leg rocking leg back & forth." And "[Telephone call] to Dr. Manchester regarding pain. New order received for pain management."

14. A note for February 7, 2002 states, "increased erythema and open area [right] foot increased depth [around] tendon area, skin warm, c/o constant pain, brownish red drainage on old [dressing]. when resident [applies] pressure to base of foot thick yellow green drainage oozes out of open area." A telephone call was made to the vascular surgeon regarding the patient's condition. Patient A's daughter asked that a do not resuscitate (DNR) order be entered in her father's chart.

15. On February 7, 2002, the daughter of Patient A terminated Respondent's medical care of her father and replaced him with another physician from the St. Albans area.[5]

C. The Subsequent Course.

16. In the following weeks, Patient A was treated with IV infusions of antibiotics and received opioid painkillers. Patient A experienced recurring confusion, occasional delusions, and ongoing pain, with instances of severe breakthrough pain. The open pressure ulcer on his ankle worsened. A note in the patient's chart for February 11, 2002 states, "[Dressing changed] to [right] foot 4.5 cm [left] area of tendon exposed wound 2 cm wide.

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5. Between November 6, 2001 and February 7, 2002, Respondent came to the nursing home two times to examine his patient's pressure ulcers. Both visits were in response to repeated requests from nursing staff indicating the patient's condition and urging Respondent to personally examine the patient.

Yellow green drainage from wound. erythema [around] wound. [Right] outer ankle reddened [with no] drainage." On February 11, 2002, Patient A was transferred to Fletcher Allen Health Care on the orders of his new doctor. Shortly thereafter, his right leg was amputated above the knee.[6]

D. The Account of the Patient's Daughter.

17. In a detailed complaint to the Board, Patient A's daughter summarized her dissatisfaction with Respondent's care of her father in the year 2002:

> Dr. Manchester was my father's primary physician while he was a resident at the [nursing home]. *** From the first phone call on January 17th regarding the right ankle [open sore] until he was replaced by another physician on February 7th Dr. Manchester visited my father at the nursing home exactly once. [T]he director of nursing personally called Dr. Manchester's office to tell him he needed to come and see my father and check his ankle and [see] how serious it was. Also a physician from the nursing home was called in to see my father after Dr. Manchester didn't come in to see him on [January 31].
>
> [M]y father suffered an excruciating amount of pain that was unnecessary as well as suffering from delirium and hallucinations for much of the time during the latter part of this process. By the time of amputation he had an open area on his leg that was approximately three inches long and at least an inch and a half wide. The tendon was totally exposed and . . . would have been easily visible to Dr. Manchester had he . . . come in as requested.

18. In retrospect, Dr. Manchester observed that he had "misjudged the acuity of the problem". The assigned Board investigative committee believed that the repeated communications from the nursing home had indicated a clear, urgent need for prompt examination and medical care of the open ulcer on the patient's ankle.[7] The investigative

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6. Patient A returned to the nursing home following amputation. He subsequently experienced continuing pain and discomfort, declined slowly, refused any transfer for hospital care, entered hospice, and died at the end of April 2002 with his family present.

7. Dr. Manchester described the patient's open sore as a Grade III ulcer. A Grade (Stage) III ulcer involves a wound that extends through all layers of the skin. It becomes a primary site for a serious infection and, if not properly attended, can progress very rapidly.

committee was troubled that Respondent did not appear to have recognized the need for earlier, more aggressive intervention and treatment of his patient's worsening pressure ulcer and his other areas of sore and broken skin. Following review of the facts, the investigative committee's members concluded that more engaged and more aggressive care of the patient's medical needs by Respondent might have produced a different and better outcome.

II. MPC 24-0203: Methadone Prescribing.

19. On April 14, 2003, the Board opened another complaint involving Respondent's medical practice. The complaint grew out of the arrest by the police of an individual, who was found to be in possession of a pill vial with a label indicating that the contents were methadone 10 mg. tablets, prescribed for him by Respondent.

A. Methadone Prescribing for Patient B.

20. Pharmacy records indicated that Respondent had prescribed quantities of methadone for the individual (hereinafter referred to as Patient B) on many occasions, beginning in October 2001. Respondent prescribed 100 mg. of methadone per day for this patient, on a roughly weekly basis. Investigation determined that Patient B, the arrested individual, allegedly also was concurrently being prescribed methadone by a physician in Arizona.

21. During an investigative interview on January 28, 2003 Respondent Manchester reportedly provided the following information regarding his care and treatment of Patient B:

a. Respondent confirmed that the individual was a former patient; Respondent confirmed that he had prescribed methadone tablets for the patient on more than one occasion;

b. Respondent stated that he had treated the patient for pain associated with medical conditions that included back injury, heart surgery, and cancer;

c. Respondent stated that he was aware that the patient allegedly had participated in treatment for heroin use in Arizona; Respondent stated that he was aware the patient had been treated by another physician in Arizona but had not requested the patient's medical records from the Arizona physician;

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d. Respondent reviewed with the police a number of original prescriptions for methadone that he had been written for the patient; copies of the prescriptions had been obtained from a St. Albans-area pharmacy; Respondent confirmed that he had signed the prescriptions; Respondent also stated that he had signed one or more post-dated prescriptions for methadone for the patient.

e. Respondent reiterated that he had treated the patient for a number of specific medical conditions and specifically stated that he had treated the patient for "narcotics addiction".

B. Respondent's Statements to the Board Investigator.

22. On March 28, 2003, Philip J. Ciotti, investigator for the Board of Medical Practice, spoke by telephone with Respondent. Respondent stated that he treated the patient primarily for pain. He stated that the patient had suffered back pain but earlier had been in an out-of-state program related to his drug abuse problems.

23. Respondent told investigator Ciotti that the patient had been "terminated" from his care. The decision to terminate care apparently came in October 2002. Respondent stated that the patient (a) had become confrontational with staff of his medical office; (b) allegedly obtained a narcotics prescription from another doctor in St. Albans; and (c) claimed to have "lost" controlled substance prescriptions.

24. Respondent told investigator Ciotti that following the above events he was contacted by an individual associated with a Burlington-area drug treatment program. The individual purportedly "urged" Respondent to continue to prescribe methadone for the "former" patient until the patient could be admitted to the program for drug treatment.[8] Respondent said that he reluctantly continued prescribing methadone for the former patient.

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8. Investigators for the Board of Medical Practice determined that Patient B was known to a staff member at a Burlington-area drug treatment program, but Patient B had not actually been "admitted" to the treatment program or scheduled for treatment. The staff member confirmed that he had spoken with Respondent regarding Patient B. The staff member recalled that he had hoped that Respondent would continue to treat Patient B until the patient could be admitted to the treatment program. The staff member denied he "urged Respondent to continue to prescribe methadone for the patient.

Respondent ended his prescribing for the patient after an anonymous telephone call to his office on January 8, 2003 alleged that the patient had been selling his methadone to other persons.

C. Review of Medical Records for Patient B.

25. Investigator Ciotti verified from medical records that Respondent repeatedly prescribed methadone for the patient between late 2001 and early 2003 and that the patient regularly called Respondent's office by telephone requesting such prescriptions. Respondent's medical records included references to the patient's past use of heroin and past treatment for substance abuse problems.

26. The patient's medical records included assessments by Respondent of the patient's numerous medical needs, and included the following assessments: "Mechanical back pain [and] Narcotic addiction" (10-12-01); "Mechanical back pain [and] Narcotic addition [sic]" (10-26-01); "Back pain and narcotic addiction" (11-27-01); "Methadone maintenance" (1-4-02); "Back pain [and] Narcotic addiction" (3-29-02); and "Narcotic addiction" (4-16-02). A telephone message slip in the patient's file for October 12, 2001 states, "Problem: heroin addict – can't get methadone or help – wants to see SM".

27. Respondent's medical records for the patient included only the most general information regarding Respondent's care of the patient for his addiction problems and claimed pain. Respondent saw the patient relatively infrequently and his plan of care for the patient often included no more than continued prescribing. The records appear to include no referrals to specialists or clinics for treatment of the patient's pain or for assessment and treatment of his underlying medical conditions. The records include no written narcotic

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contract or agreement between Respondent and Patient B as to the terms of his treatment or the controlled substances being prescribed for him.

D. Respondent's Continuing Prescribing of Methadone for Patient B.

28. Respondent told investigator Ciotti that he continued to prescribe methadone for his "former" patient even after he had "terminated" the patient from his practice.[9] See Paragraph 23, above. Respondent stated that this prescribing was against his better judgment. He did so, he said, while the patient was waiting to be admitted to drug treatment. Respondent's medical records for the patient include no written entries reflecting continuing treatment or prescribing for him by Respondent after mid-October 2002.[10]

E. Respondent's Methadone Prescribing for Patient C.

29. The Board's investigation determined that Respondent prescribed methadone for at least one other individual (hereinafter referred to as Patient C) with alleged substance abuse problems. Patient C, a male in his 30s, was first seen by Respondent in 1999. Patient C had a history of physical, cognitive, emotional, substance abuse, and dependency problems. Respondent's written medical records for his care of Patient C include the following entries:

September 25, 2001: "C/o F/up Drug & Alcohol Addiction"
"He is here for f/up of his drug and alcohol addiction."
"He is still having some challenges with heroin."
Assessment: "Drug & alcohol addiction."

October 9, 2001: "C/o F/up Drug & Alcohol Addiction"
"He is here for f/up on his alcohol and drug addiction."
". . . is still on a 5 daily basis having difficulties using heroin."
Assessment: 1. Alcohol & drug addiction. 2. Depression. Plan 2.
"We will start him on Methadone 10 mg #4 daily for one week, #3 daily for one week, #2 daily for one week, and #1 daily for one week"

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9. The patient's medical records indicate that the patient was notified on or about October 15, 2002 that "effective immediately" Respondent would assist in transferring the patient's care to another physician. However, the patient's records include no written termination notice directed to the patient.

10. Respondent stated that he had given one or more prescriptions for methadone to the patient while the two were at a location other than his office because he did not want the individual to again visit his medical practice.

October 30, 2001: **"C/o F/up Drug & Alcohol Addiction"**
"He is here for f/up on alcohol and drug addiction. Is presently Only using marijuana and his Methadone rx as wells as diazepam. He is not using any IV medication. He denies any alcohol use."
Assessment: Drug and alcohol addiction.
Plan: "He will continue same medications."

November 27, 2001: **"C/o F/up Depression, Cyst R Ear, F/up Narcotic Abuse"**
"He is here for f/up as above. Continues to do well. He has no alcohol, no cocaine and no heroin. Is taking diazepam 10 mg TID, Methadone 10 mg TID, Celexa 20 mg daily, and Aciphex 20 Mg daily
Assessment: 1. Infected cyst R ear. 2. Depression. 3. Narcotic Addiction. 4. Gastritis.
Plan: "1. We will have him continue his same medications. 2. We Will increase his Celexa to 40 mg daily."

January 2, 2002: **"F/up Depression, F/up Narcotic Abuse, F/up Gastric, L Leg Spasticity"**
"Continues on his same dose of Methadone and his same dose of Celexa. Finds that he is presently stable, has avoided cocaine, heroin, alcohol and marijuana.
Assessment: 1. Depression. 2. Gastritis. 3. Narcotic addiction. 4. L leg spasticity secondary to cerebral palsy.
Plan: "He will continue his same medications."

January 23, 2002: **"C/o F/up Depression, F/up Narcotic Addiction."**
"He has continued to meet his challenges, continues to be attempting to improve his situation."
Assessment: 1. Depression. 2. Narcotic addiction.
Plan: "He will continue his same medications as per our list."

February 6, 2002: **"C/o F/up Cerebral Palsy, F/uDepression, F/up Narcotic Addiction**
"Is attending PT, find that ROM in his legs is improving on a steady basis. Spasticity has decreased. He is attending AA on a daily basis, feels more confident and calm."
Assessment: 1. Chronic pain syndrome[11] and Narcotic addiction. 2. Cerebral palsy. 3. Depression.
Plan: "He will continue his same medications."

February 21, 2002: **"Fatigue & Hematuria"**
"He is here for increasing fatigue and hematuria. He is concerned about his kidney function and also perhaps his liver function because of past drug abuse.
Assessment: 1. Hematuria. 2. Fatigue.
Plan: "We will f/up otherwise in 2 months."

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11. Respondent's reference to "Chronic pain syndrome" appears in the office note for February 6, 2002 without substantive discussion of any complaint of pain by the patient, identification of objective findings, or reference to assessment to the source, severity, and nature of the pain. Patient C's medical records, as prepared by Respondent, included few other references to "pain" or attempts to identify a source.

April 1, 2002: **"C/o F/up Depression & Narcotic Addiction**
"He is here for f/up on his depression and narcotic addiction. He has had his medications stolen [from] his car."[12]
Assessment: 1. Narcotic addiction and depression.
Plan: "He was [given] repeat prescriptions of his medications and warned to keep them locked up as they are controlled medications."

April 30, 2002: **"C/o Gastritis & F/up Depression, F/up Narcotic Addiction"**
"He is here for f/up as above. * * * He has been using valium now 10 mg twice a day. Continues on his same dose of Methadone."
Assessment: 1. Gastritis. 2. Narcotic addiction. 3. Depression.
Plan: "He will continue his same medications."

May 29, 2002: **"C/o F/up Depression, F/up Gastritis, F/up Narcotic Addiction"**
"He is here for f/up as above. Is continuing to be stable.[13] He still has some early morning vomiting and acid."
Assessment: 1. Depression. 2. Narcotic addiction. 3. Gastritis.
Plan: Rx Atarax, Protonix, d/c Valium, "he will f/up otherwise PRN."

June 24, 2002: **"F/up Depression, F/up Narcotic Addiction, F/up Gastritis"**
"He is here for f/up as above. Continues on his same medications as per our list."
Assessment: 1. Depression. 2. Narcotic addiction. 3. Gastritis.
Plan: "We will increase his Celexa to 60 mg daily. He will continue his same medications. F/up otherwise PRN."

30. Respondent saw Patient C on August 14, 2002. His office note assessed the patient with narcotic addiction. The note also stated, "[Patient] is doing counseling and Voc. Rehab. Is seeing Dr. Duncan of psychiatry who has started him on Seroquel 330 mg. TID." The plan of care included the following, "All of his other medications will be ordered by Dr. Duncan." However, the patient's records include a later note for August 22, 2002 stating, "[Patient] wants Methadone ASAP." Another note the next day, initialed by Respondent states, "written script done—o.k. but in future all meds from Dr. Duncan".

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12. An assessments of Patient C by a rehabilitation counselor referred to an earlier, similar theft of methadone from the patient's car, "[Patient] has a serious legal dilemma due to his substance abuse. The theft of methadone from his car in January 2002 resulted in the death of another person."

13. A note in Patient C's chart, dated May 21, 2002 and bearing Respondent's initials, includes the following, "[Patient C's mother] would like a call from SM [Stewart Manchester] in an effort to try to have more mental help for [him]. She observes irrational, unglued behavior, [he] thinks people who love him are against him, hopelessness, poor decision making, in trouble [with] courts. * * * [His] Only counselor [at] this time is substance abuse [once a] month [with] [name deleted]." However, Patient C's subsequent office visit with Respondent on May 29, 2002 includes no written entry indicating that the mother's concerns regarding the patient's mental health were addressed during the patient's visit with Respondent on that date.

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31. Respondent saw Patient C again on September 17, 2002. The office note for this date states, "He is here for f/up [as to depressions and narcotic addiction]. His depression is being managed by Dr. Duncan with good effect. Seems to be stabilizing. Dr. Duncan, however, will not re-write his Methadone. Therefore, he is requiring refill later this month." (Emphasis added.) The plan of care included the following, "1. He will continue same medications per Dr. Duncan. 2. We will refill his Methadone until the clinic is available in Burlington." The office note included no explanation or detail regarding the second point.

32. On September 25, 2002, Patient C called Respondent's office and the following note was entered in his chart, "[Patient] wants methadone 10 mg." An office note dated November 22, 2002 stated, "[Patient] wants written script for methadone 10 mg." A follow-up office note for November 25, 2002 stated, "written script done—script out front." A second note stated, "[Patient] aware script out front . . . He does not have an [appointment at] the methadone clinic, but he will call and [check] out their system to see if its 'convenient' for him." (Emphasis in original.) Respondent's initials appear at the bottom of the note.

33. Although it is not entirely clear from the patient's medical records, it appears that after the above interaction, Patient C's care was transferred to another physician.[14] The Board's investigator was unable to identify any document prepared by Respondent indicating the reason for the transfer or summarizing for the other physician Respondent's care and treatment of Patient C or the patient's medical needs.

34. In sum, Respondent's medical records for Patient C did follow the SOAP format but generally lacked detail regarding the patient's complaint, condition, medical needs, the physician's assessment, and plan of care. The records generally provided only minimal,

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14. Respondent's last prescription of methadone for the patient was written in late-December 2002.

often superficial information regarding Respondent's care of the patient for substance abuse and dependency problems. The records often repeated the same non-specific phrasing regarding the patient's medical needs. The records for Patient C include no referrals to specialists or clinics for consultation or treatment of the patient's substance abuse and dependency problems and do not reflect at best minimal efforts by Respondent to foster Patient C's involvement in treatment for these problems. The content of the patient's medical records, as prepared by Respondent, make clear that Dr. Manchester's repeated prescribing of methadone for the patient was not for the treatment of pain or an underlying physical problem, but rather for purposes of "methadone maintenance" or, arguably, for "treatment" of the patient's addiction problems. The records include no written narcotic contract or agreement between Respondent and the patient regarding his treatment and the controlled substances being prescribed for him. The medical records include no clear objectives or long-term plan of treatment.

III. Characteristics and DEA Classification of Methadone.

35. Methadone hydrochloride is "A synthetic opioid analgesic with a long duration of action, used primarily to treat pain and to detoxify or maintain patients who are addicted to narcotic pain relievers. Methadone is habit-forming and subject to abuse; its use should be carefully supervised." Taber's Cyclopedic Medical Dictionary (19th ed.) at 1343. Methadone is a Drug Enforcement Administration (DEA) Schedule II narcotic controlled substance. Methadone is a drug that is subject to diversion and illicit sale. When used in combination with other controlled substances, methadone has been implicated in emergency room overdose admissions and some deaths.

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36. Until January 2001, Federal regulations did not permit individual physicians to prescribe narcotic drugs, including opioid agonist medications such as methadone, for the treatment of patients with a narcotic addiction. Since that date, Federal regulations have been promulgated that provide in detail for government certification and regulation of programs and practitioners seeking to treat medical, psychological, or physical effects related to opiate addiction. See 42 CFR, Part 8, §§ 8.1–8.34.

37. The State of Vermont adopted rules, effective May 21, 2001, requiring written authorization from the Vermont Department of Health for any program seeking to provide opiate addiction treatment. The State's rule requires that "Prior to operating, opiate addiction treatment programs must receive written authorization by the Vermont Department of Health" and must comply with the Department's requirements with regard to treatment. Respondent has not received such authorization or certification.

IV. Imposition of Board Sanction in Each Case.

38. Consistent with his continuing cooperation with the Board, Respondent has determined, with the assistance of counsel, that he wishes to resolve the two docketed matters addressed herein by entering into agreement with the Board of Medical Practice. The State and Respondent agree that the time and expense of a public proceeding is not required to achieve a satisfactory disposition of these matters. The parties have conferred and agree that appropriate resolution will consist of the imposition of specific terms and conditions on Respondent's Vermont medical license and entry of a public reprimand by the Board in each case.

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39. Respondent acknowledges that he is agreeing voluntarily and knowingly to this Stipulation and Consent Order. He acknowledges that he has had advice of counsel in

reviewing this Stipulation and Consent Order. He is fully satisfied with the assistance of counsel that he has received. He agrees and understands that by executing this document he is waiving any right to be served with formal charges, to challenge the jurisdiction and continuing jurisdiction of the Board in these matters, to be presented with the evidence against him, to cross-examine adverse witnesses, and to offer evidence of his own to contest the State's charges. 26 V.S.A. § 1356; 3 V.S.A. §§ 809, & 814.

A. Docket No. MPC 75-0702: Care of Nursing Home Patient.

40. Respondent has reviewed the State's allegations with regard to his care of Patient A. See Paragraphs 3 through 18, above. Respondent disagrees with certain aspects of the State's recitation of facts in this matter but concedes for purposes of this proceeding that he did not respond promptly on one or more occasions when asked to come to the nursing home to care for his patient, or when it would have been appropriate for him to do so, on his own initiative. Thus, for the limited purposes of this agreement only and to expeditiously resolve this matter, he will not contest the facts set forth above in paragraphs 3 through 18, above, and agrees that the Board of Medical Practice may adopt and enter these paragraphs as its findings of fact in this matter.

41. Respondent admits that based on the facts generally set forth in paragraphs 3 through 18, above, the Board of Medical Practice could enter a finding adverse to him under 26 V.S.A. §§ 1354 and *1361*, if this matter had proceeded to public hearing and the State had satisfied its evidentiary burden. Notwithstanding Respondent's belief that he could present evidence of mitigating circumstances, he expressly agrees here that his actions failed to satisfy his own standards of careful record keeping. In sum, Respondent agrees that the Board of

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Medical Practice may adopt this paragraph and paragraphs 3 through 18 as its findings and conclusions in this proceeding.

B. Docket No. MPC 24-0203: Methadone Prescribing.

42. Respondent has reviewed the State's allegations with regard to his care and prescribing for Patients B and C. See Paragraphs 19 through 37, above. Again, Respondent disagrees with certain aspects of the State's recitation of facts in this matter but concedes for the purposes of this proceeding and for the limited purposes of this agreement only, as well as and to expeditiously resolve this matter, that his prescribing practices in caring for Patients B and C were inappropriate and unprofessional. Respondent admits that in attempting to care for the multiple medical needs of these difficult patients, including their history of substance use, abuse, and addiction, his prescribing practices with regard to methadone were inconsistent with governmental requirements. See 42 CFR, Part 8, §§ 8.1—8.34 (Federal regulations governing opioid treatment programs); and rules promulgated by the Vermont Department of Health, effective May 21, 2001 (requiring written authorization from the Department for any program seeking to provide opiate addiction treatment). Respondent admits that he had not received certification or authorization to engage in the treatment of opiate addiction at the time of his care and prescribing for Patients B and C.

43. Respondent admits that based on the facts generally set forth in paragraphs 19 through 37, above, the Board of Medical Practice could enter a finding adverse to him under 26 V.S.A. §§ 1354 and 1361, if this matter had proceeded to public hearing and the State had satisfied its evidentiary burden. Respondent expressly admits that his prescribing practices with regard to Patients B and C did not comply with applicable requirements of Federal regulations and rules of the Vermont Department of Health and thus, his prescribing for these patients

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constitutes a violation of 26 V.S.A. § 1354(a)(27) (failure to comply with provisions of federal or state statutes or rules governing the practice of medicine constitutes unprofessional conduct). In sum, Respondent agrees that the Board of Medical Practice may adopt paragraphs 19 through 37, above, and this paragraph as its findings and conclusions in this proceeding.[15]

C. Terms and Conditions of Sanction.

44. The parties to this Stipulation and Consent Order agree that appropriate disciplinary action by the Board in Docket Nos. MPC 75-0702 and MPC 24-0203 shall consist of the following:

A. Respondent's license to practice medicine shall be designated as "conditioned" for a period of thirty-six (36) months from the effective date of the Board's Order approving this Agreement; Respondent shall comply fully and in good faith with each of the terms and conditions of licensure set forth below, wherever he may practice, until he has been relieved of all conditions herein by express written order of the Vermont Board of Medical Practice. Respondent may continue the practice of medicine, subject to his full compliance with all the terms and conditions of licensure set forth herein.

B. Stayed Suspension: Substantial or repeated failure by Respondent to comply in the future with any of the material terms and conditions herein may constitute unprofessional conduct and, if established by the State's evidence, shall result in actual suspension of Respondent's license to practice medicine for 36 months and such other disciplinary action as the Board may deem appropriate under the circumstances.

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15. To be clear, the parties are in accord that addiction to heroin and other opioids is a serious problem that is prevalent in both urban and rural settings. Addiction produces social, legal, and medical consequences of the greatest concern. Current knowledge and means of treatment may offer care to many patients who suffer opioid addiction and may contribute to reducing the morbidity, mortality, and fiscal costs associated with addiction. However, in this case the committee's review of the facts raised concerns related to the alleged involvement of the patients with the criminal justice system and with the reasonable likelihood that Respondent may have failed to recognize drug-seeking behaviors that should have warranted greater vigilance on his part.

C. Respondent shall be publicly **REPRIMANDED** by the Vermont Board of Medical Practice for the conduct set forth above in MPC 75-0702.

D. Respondent also shall be publicly **REPRIMANDED** by the Vermont Board of Medical Practice for the conduct set forth above in MPC 24-0203, in addition to the imposition of the disciplinary terms and conditions set forth herein and below.

45. No specification of charges has been filed by the State in this matter. Respondent has not previously been the subject of disciplinary action by the Vermont Board of Medical Practice.

V. Specific Terms and Conditions to be Imposed on Respondent's Medical License.

A. General.

46. Respondent agrees that he has read and carefully considered all terms and conditions herein. He agrees to accept and be bound by these while licensed to practice medicine in the State of Vermont or elsewhere and to be bound by these until such time in the future as he may be expressly relieved of these conditions, in writing, by the Vermont Board of Medical Practice. The Board, in its sole discretion, may consider a petition from Respondent for partial relief from or modification of these conditions, no sooner than 12 months after the effective date of this Stipulation and Consent Order, unless a petition for modification at any earlier date is otherwise expressly provided for, elsewhere herein.

47. Respondent's license to practice medicine in the State of Vermont shall be conditioned for a minimum of 36 (thirty-six)months), following entry of the Board's Order approving the terms of this agreement. Respondent's Vermont license to practice medicine shall include the designation "Conditioned" until such time as **all** terms and conditions upon his medical license have been removed.

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48. During the period that Respondent's license is conditioned he shall comply fully with all the requirements set forth herein. Respondent also agrees that he shall abide by and follow all recommendations that are presented to him by those conducting those training courses that he is required to attend under the terms of this agreement. He expressly agrees that he shall promptly sign any and all necessary consents and/or waivers of confidentiality as to his participation in such training, to permit full and complete disclosure so as to permit the Board to monitor his participation.

B. Mentoring and Consultation.

49. Respondent agrees that he shall meet in regular consultation with a responsible peer physician regarding his pain management, and prescribing practices. Such regular consultation shall occur at least weekly. Respondent agrees to inform the Board in writing of the practitioner proposed to act as a "mentoring physician." The physician proposed by Respondent for this purpose shall be subject to approval or disapproval by the Board in its sole discretion and shall not be directly affiliated in practice with Respondent. Respondent shall provide a current c.v. for the proposed mentoring physician with his request to the Board for approval. Following the passage of at least 12 months, Respondent may petition for modification of this agreement to permit the consultation required by this paragraph to be reduced to twice monthly. Thereafter, following the passage of at least an additional 12 months, Respondent may request further modification of this requirement. The Board in its sole discretion may approve or disapprove any such petition.

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C. Disclosure.

50. Respondent agrees that he shall provide a complete copy of this Stipulation and Consent Order to any and all licensed practitioners with whom he is associated in his St. Albans practice, to any prospective employer, and to any State medical board or other licensing authority in any location or jurisdiction where he may seek to practice or where he may make application, so long as this agreement remains in effect.

D. Prescribing and Dispensing.

51. Respondent agrees that during the life of this agreement he shall not treat or prescribe for patients who suffer from opioid addiction, who are users of opioids not legally prescribed, who are detoxifying, or who are in recovery from or attempting to recover from opioid addiction. Such patients shall be promptly transferred to another physician for care.

52. Respondent agrees that until he completes the educational coursework with specific regard to the prescribing of controlled substances and record keeping, he shall prescribe no DEA Schedule I and II controlled substances and no Schedule III opiates to any patient. See Section E, Paragraph 61 (Controlled Substance Management), below. Until such time as these two courses have been completed he may only recommend in writing to other licensees in his office practice (or other practitioners who may be approved by the Board) that such DEA Schedule controlled substances be prescribed for patients, stating in writing the basis and reason for each such recommendation by him. Any costs related to this requirement shall be borne by Respondent. However, this requirement shall not apply to emergency room practice by Respondent or to the care of patients hospitalized for acute care who may require short-term care and prescribing.

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53. During the life of this agreement, Respondent shall not prescribe methadone to any patient for any reason, absent compelling circumstances. For those patients who appear to require methadone, Respondent shall first consider transfer of the patient, if practicable, to another practitioner who can care for that patient to the extent that prescribing methadone is required. Should such transfer not be practicable or medically advisable, Respondent shall follow the procedure set forth above, i.e., he may only recommend in writing to other licensees in his office practice (or other practitioners who may be approved by the Board) that methadone be prescribed for a patient. He shall state in writing the basis and reason for each such recommendation by him. Respondent shall provide prompt written notice to the Board of Medical Practice of any such recommendation, with a clear written explanation as to why transfer of the patient was not practicable or medically advisable.

54. During the life of this agreement Respondent agrees that each office patient for whom he prescribes controlled substances in the course of his practice shall have a current diagnostic assessment and treatment plan which shall be available for review by the Board at any time while conditions remain upon Respondent's license to practice medicine. Each such plan shall include specific entries regarding the patient's diagnosis or condition and the rationale for prescribing each such controlled substance for the patient. Upon request, each such plan shall be promptly made available for review by the Board or its agents.

55. Each controlled substance that is prescribed for a patient shall be clearly noted in writing in the patient's office record with the date of prescribing indicated. Medical records of patients cared for by Respondent may be reviewed at any time by the Board or its agents, pursuant to 18 V.S.A. § 4218(c), other applicable authorities, and/or the terms and conditions herein, to determine compliance with this agreement. The requirements of this paragraph are

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not intended to apply to those infrequent occasions in which Respondent is providing call coverage for another physician, and it is medically necessary to prescribe a controlled substance for patients of the other physician. Nonetheless, in such a circumstance, Respondent shall prepare a written record for later inclusion in the patient's chart.

56. Respondent agrees that all prescriptions by him for DEA schedule controlled substances for patients seen at his office shall be copied and retained in triplicate during the life of this agreement. One copy of each such prescription shall be placed in the patient's chart, a second copy shall be kept in a chronologically ordered file that shall be made available for review by the Board or its agents, at any time and without prior notice. The third copy of each such prescription shall be retained, and every three months all such copies on hand shall be promptly forwarded to the Board of Medical Practice for review. This record-keeping requirement does not apply to patients seen or treated in a hospital or nursing home. But see below.

57. Respondent agrees that he shall read and adhere to (a) the Model Policy Guidelines of the Federation of State Medical Boards for Opioid Addiction Treatment in the Medical Office; and (b) the Prescribing Practices Committee Report on Chronic Pain Management (June 5, 1996), Vermont Board of Medical Practice.

E. Nursing Home Care.

58. Respondent agrees that he shall respond promptly to all inquiries and requests for examination and/or care of any of his patients who are confined to or residents of nursing homes, assisted living facilities, or residences designated for the elderly or disabled. Respondent's telephone or other reply be made within four hours after receipt of the

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incoming communication, absent compelling circumstances. Respondent or his office staff shall be responsible for clearly and accurately recording the dates and times of incoming communications and the date, time, and specifics of the response and the name of the individual responding. Respondent agrees that whenever possible he personally shall respond to incoming communications from patients. Respondent shall continue to monitor intra-office communications protocols within his practice and shall ensure that incoming messages regarding patient care are promptly and accurately conveyed to the appropriate individual practitioners.

59. Respondent's chart entries and orders for nursing home patients shall be dictated, transcribed, and made available for inclusion in the patient's chart. Entries in all cases shall follow the SOAP format and shall provide sufficient detail to indicate clearly the nature of examination and care that occurred, results and observations, orders, and the date and time.

60. Respondent shall see and examine all patients who are confined to a care facility at least once a month.

61. Respondent shall personally write a letter of apology to the daughter of Patient A. The letter in draft form shall be forwarded to the Board's Central Investigative Committee for its review and approval prior to being sent to the complainant. Any such letter of apology is for the purposes of this agreement and is not entered by Respondent as an admission of legal liability with regard to any other forum.

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F. Education.

62. Respondent agrees that within one year following approval of this Stipulation and Consent Order he shall satisfactorily complete, at his own expense, educational courses or

programs that shall be subject to review and approval, in its sole discretion, of the Board of Medical Practice. Such coursework shall address: (a) medical record keeping; (b) the legal and medical requirements related to the handling, distribution, and prescribing of controlled substances; (c) physician ethics and professionalism; and (d) care of decubitus ulcers. See below.

63. **Medical Record Keeping:** Respondent agrees that he shall promptly attend and successfully complete (a) the on-site, two-day intensive course in medical record keeping which is offered by the School of Medicine of the Case Western Reserve University; and (b) the program's additional chart review and feedback activities that occur at three months and six months after completion of the on-site course. Respondent agrees that his attendance shall take place as soon as reasonably practicable, i.e., upon the first occasion that such course is offered following the effective date of this agreement. Respondent agrees that he shall document his attendance and successful completion of this coursework by prompt submission to the Board of appropriate certification, documentation, and/or evaluation of his coursework. Respondent shall bear all costs.

64. The above coursework must be eligible for credit as "continuing medical education" and be eligible for total credits of at least 17.5 hours in Category I of the Physician's Recognition Award of the American Medical Association. Respondent's participation must earn the full 17.5 hours of credits for such course work. Respondent shall be responsible for ensuring that documentation of and evaluations of Respondent's participation in and satisfactory completion of such coursework are promptly forwarded to the Board of Medical Practice for its review. Such documentation must be provided in a manner and form

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satisfactory to the Board and in no case later than 30 days after Respondent's completion of any individual course. Respondent shall bear all costs.

65. Controlled Substance Management: Respondent agrees that he shall promptly attend and successfully complete the four-day intensive course in controlled substance management which is offered by the School of Medicine of the Case Western Reserve University. Respondent agrees that his attendance shall take place as soon as reasonably practicable, i.e., upon the first occasion that such course is offered following the effective date of this agreement. Respondent agrees that he shall document his attendance and successful completion of this coursework by prompt submission to the Board of appropriate certification, documentation, and/or evaluation of his coursework. Respondent shall bear all costs.

66. The above coursework must be eligible for credit as "continuing medical education" and be eligible for a total credit of at least 40.0 hours in Category I of the Physician's Recognition Award of the American Medical Association. Respondent's participation must earn the full 40.0 hours of credits for such course work. Respondent shall be responsible for ensuring that documentation of and evaluations of Respondent's participation in and satisfactory completion of such coursework are promptly forwarded to the Board of Medical Practice for its review. Such documentation must be provided in a manner and form satisfactory to the Board and in no case later than 30 days after Respondent's completion of any individual course. Respondent shall bear all costs.

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67. Medical Ethics and Professionalism: Respondent agrees that he shall promptly attend and successfully complete the two day intensive course in medical ethics and professionalism which is offered by the School of Medicine of the Case Western Reserve

University. Respondent agrees that his attendance shall take place as soon as reasonably practicable, i.e., upon the first occasion that such course is offered following the effective date of this agreement. Respondent agrees that he shall document his attendance and successful completion of this coursework by prompt submission to the Board of appropriate certification, documentation, and/or evaluation of his coursework. Respondent shall bear all costs.

68. The above coursework must be eligible for credit as "continuing medical education" and be eligible for a total credit of at least 16 hours in Category I of the Physician's Recognition Award of the American Medical Association. Respondent's participation must earn the full 16 hours of credits for such course work. Respondent shall be responsible for ensuring that documentation of and evaluations of Respondent's participation in and satisfactory completion of such coursework are promptly forwarded to the Board of Medical Practice for its review. Such documentation must be provided in a manner and form satisfactory to the Board and in no case later than 30 days after Respondent's completion of any individual course. Respondent shall bear all costs.

69. Prevention, Care, and Treatment of Decubitus Ulcers: Respondent agrees that he shall promptly pursue and successfully complete at least 25 hours of on-site coursework in the prevention, care, and treatment of decubitus ulcers at a recognized teaching institution. Such coursework shall be completed within one year of the effective date of this agreement. Respondent agrees that he shall document his attendance and successful completion of this coursework by prompt submission to the Board of appropriate certification, documentation, and/or evaluation of his coursework. Respondent shall bear all costs.

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70. The above coursework must be eligible for credit as "continuing medical education" and be eligible for a total credit of at least 25 hours in Category I of the Physician's Recognition Award of the American Medical Association. Respondent's participation must earn the full 25 hours of credits for such course work. Respondent shall be responsible for ensuring that documentation of and evaluations of Respondent's participation in and satisfactory completion of such coursework are promptly forwarded to the Board of Medical Practice for its review. Such documentation must be provided in a manner and form satisfactory to the Board and in no case later than 30 days after Respondent's completion of any individual course. Respondent shall bear all costs.

71. This agreement identifies certain required coursework at the Case Western Reserve University. The parties agree, however, that Respondent may propose coursework at alternative institutions or locations, provided that such alternative coursework is substantially equivalent in content to the specified courses and satisfies the required number of CME credits identified above. Respondent shall be responsible for identifying and timely proposing any such alternative coursework. In no case, shall any such proposal result in substantial delay of coursework completion or reduction in the number of required CME credits. The Board in its sole discretion may approve or disapprove any such petition from Respondent.

VI. Other Terms and Conditions as to Implementation.

72. Respondent acknowledges and agrees that engaging in further unprofessional conduct, as set forth in 26 VSA §§1354 & 1398, may constitute prima facie evidence of a violation by him of this agreement sufficient to support findings by the Board that the present terms and conditions of this agreement are inadequate to protect the health, safety and welfare

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of the public, and thus, could result in a motion by the State for suspension of Respondent's medical license.

73. The parties agree that this Stipulation and Consent Order shall be a public document, shall be made part of Respondent's licensing file, and may be reported to other licensing authorities and/or entities including, but not limited to, the National Practitioner Data Bank and the Federation of State Medical Boards.

74. This Stipulation and Consent Order is subject to review and acceptance by the Vermont Board of Medical Practice and shall not become effective until presented to and approved by the Board. If the Board rejects any part of this Stipulation and Consent Order, the entire agreement shall be considered void. However, should the terms and conditions of this Stipulation and Consent Order be deemed acceptable by the Board, the parties request that the Board enter an order conditioning and restricting Respondent's license to practice medicine as set forth above, that such license be subject to each of the terms and conditions as set forth herein, and further that

> **RESPONDENT STEWART P. MANCHESTER, M.D., SHALL BE PUBLICLY REPRIMANDED** by the Vermont Board of Medical Practice for the conduct set forth herein in Docket No. MPC 75-0702;
>
> **And, further, that he also shall be PUBLICLY REPRIMANDED** by the Vermont Board of Medical Practice for the conduct set forth herein in Docket No. MPC 24-0203.

75. Respondent agrees to be bound by all terms and conditions of this Stipulation and Consent Order. Respondent agrees that the Board of Medical Practice shall retain jurisdiction to enforce all terms and conditions of this Stipulation and Consent Order during its lifetime. Respondent expressly agrees that any failure by him to comply with the material

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terms of this Stipulation and Consent Order, specifically including but not limited to its record keeping, educational, and reporting requirements, may constitute unprofessional conduct under 26 V.S.A. §1354(25) and may subject Respondent to such further disciplinary action as the Board may deem appropriate.

76. This Stipulation and Consent Order is conditioned upon its acceptance by the Vermont Board of Medical Practice. If the Board rejects any part of this document, the entire agreement shall be considered void. Respondent agrees to be bound by the terms and conditions of this Stipulation and Consent Order during its lifetime. Respondent agrees that the Board of Medical Practice shall retain jurisdiction to enforce the terms and conditions of this Stipulation and Consent Order until it is modified or he is relieved of its terms and conditions, upon his written petition and Board approval, to be determined in its sole discretion.

Dated at Montpelier, Vermont, this 3rd day of ~~April~~ MAY 2004.

WILLIAM H. SORRELL
ATTORNEY GENERAL

by: _____
JAMES S. ARISMAN
Assistant Attorney General

Dated at _____, Vermont, this 29 day of April 2004.

_____
STEWART P. MANCHESTER, M.D.
Respondent

Dated at Burlington, Vermont, this 29th day of April 2004.

_____
JOHN D. MONAHAN, JR., ESQ.
Counsel for Respondent

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FOREGOING, AS TO STEWART P. MANCHESTER, M.D.

APPROVED AND ORDERED

VERMONT BOARD OF MEDICAL PRACTICE

DATED: 5/5/04

ENTERED AND EFFECTIVE: May 5, 2004

JSA, AAG/AGO: MANCHESTER STIPULATION (FINAL) 4/04 (NOT EFFECTIVE UNTIL REVIEWED AND APPROVED BY BOARD OF MEDICAL PRACTICE)

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